Filing at a Glance

Company:	Pan-American Life Insurance Company
Product Name:	Individual Life Applications Primary and Supplemental
State:	Arkansas
TOI:	L04I Individual Life - Term
Sub-TOI:	L04I.003 Single Life - Single Premium
Filing Type:	Form
Date Submitted:	10/24/2012
SERFF Tr Num:	PNAL-128740625
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	1500AR
Implementation Date Requested:	On Approval
Author(s):	San Llull
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/31/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* ***Filing Company:*** *Pan-American Life Insurance Company*
TOI/Sub-TOI: *L04I Individual Life - Term/L04I.003 Single Life - Single Premium*
Product Name: *Individual Life Applications Primary and Supplemental*
Project Name/Number: */1500AR*

General Information

Project Name:
Project Number: 1500AR
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: San Llull

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/31/2012
State Status Changed: 10/31/2012
Created By: San Llull
Corresponding Filing Tracking Number:

Filing Description:

We are filing two Life Individual applications for Term, Whole Life and Universal Life. Primary Insured and Supplemental They have been updated in the areas: the HIPAA section, the MIB Section , Fraud Notices, and a Certification above the Producer's Signature.

Company and Contact

Filing Contact Information

San Llull, Senior Compliance and Policy Analyst
601 Poydras Street
28th Floor
New Orleans, LA 70130

sllull@panamericanlife.com

504-566-3449 [Phone]
504-566-3600 [FAX]

Filing Company Information

Pan-American Life Insurance Company
601 Poydras Street
New Orleans, LA 70130
(504) 566-3449 ext. [Phone]

CoCode: 67539
Group Code: 525
Group Name:
FEIN Number: 72-0281240

State of Domicile: Louisiana
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $100.00
Retaliatory? No
Fee Explanation: 50.00 x 2
Per Company: No

Company	Amount	Date Processed	Transaction #
Pan-American Life Insurance Company	$100.00	10/24/2012	64229487

SERFF Tracking #:	*PNAL-128740625*	***State Tracking #:***		***Company Tracking #:***	*1500AR*

State:	*Arkansas*	***Filing Company:***	*Pan-American Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.003 Single Life - Single Premium*		
Product Name:	*Individual Life Applications Primary and Supplemental*		
Project Name/Number:	*/1500AR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/31/2012	10/31/2012

SERFF Tracking #:	*PNAL-128740625*	***State Tracking #:***		***Company Tracking #:***	*1500AR*

State:	*Arkansas*	***Filing Company:***	*Pan-American Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.003 Single Life - Single Premium*		
Product Name:	*Individual Life Applications Primary and Supplemental*		
Project Name/Number:	*/1500AR*		

Disposition

Disposition Date: 10/31/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	AR cover letter		Yes
Form	Primary Insured App.		Yes
Form	Supplementary Application		Yes

SERFF Tracking #:	*PNAL-128740625*	***State Tracking #:***		***Company Tracking #:***	*1500AR*

State:	*Arkansas*	***Filing Company:***	*Pan-American Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.003 Single Life - Single Premium*		
Product Name:	*Individual Life Applications Primary and Supplemental*		
Project Name/Number:	*/1500AR*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Primary Insured App.	B-1500 (AR) Rev 01-13	AEF	Initial			B1500 (AR) Rev 01-13.pdf
2		Supplementary Application	B-1501 (AR) Rev 01-13	AEF	Initial			B1501 (AR) Rev 01-13.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

PAN AMERICAN

❑Pan-American Life Insurance Company
❑Pan-American Assurance Company

P.O. Box 60219, New Orleans, LA 70160 USA

Part I of Application (Please print)

PRIMARY PROPOSED INSURED

1. a) Last Name	b) First Name	c) M. I.	d) Date of Birth	e) Age	f) Gender ❑ M ❑ F

g) Social Security Number / Cedula	h) State of Birth	i) Country of Birth *(If other than US)*	j) Citizenship	k) US Resident? ❑ Yes ❑ No

l) Residential Address	m) City	n) State/Province	o) Zip Code	p) Telephone Number

q) E-Mail Address	r) Driver's License Number	s) D.L. State	t) Current Annual Income	u) Net Worth
			$_____	$_____

v) Risk Classification *(Choose only one from the choices below.)*

❑ Preferred Plus Non-Tobacco ❑ Preferred Non-Tobacco ❑ Standard Non-Tobacco ❑ Preferred Tobacco ❑ Standard Tobacco

2. a) Name of Business *(If independent professional, indicate profession.)*	b) Nature of Business

c) Business Address	d) City	e) State/Province	f) Zip Code	g) Business Phone

h) Describe exact duties/functions of Proposed Insured's work.	i) How long in present job?

j) Presently working? ❑ Yes ❑ No *If "No," please explain under question 15, Special Instructions.*	k) Other employment in last 3 years	l) Percentage of time traveling and places traveled

3. Send premium notices & correspondence to: ❑ Insured's Address ❑ Business Address ❑ Owner's Address ❑ Other Address *(Provide address under question 15, Special Instructions.)*	4. Policy date requested *(1st to 28th only)*

5. Name of secondary addressee for the purpose of notification of past due premium payment and possible lapse in coverage.

a) Full Name	b) Residential Address	c) City	d) State/Province	e) Zip Code

PRIMARY PROPOSED INSURED BENEFICIARIES

6. a) Full Name of Primary Beneficiary	D.O.B.	Relationship	%	b) Full Name of Contingent Beneficiary	D.O.B.	Relationship	%

If you would like the beneficiary designation to be irrevocable, please indicate this under question 15, Special Instructions.

POLICY OWNER *(Complete question 7 only if Policy Owner is not Primary Proposed Insured.)*

7. a) Last Name	b) First Name	c) M. I.	d) Date of Birth

e) Residential Address	f) City	g) State/Province	h) Zip Code	i) Telephone Number

j) Social Security Number / Cedula	k) E-Mail Address	l) Relationship to Proposed Insured

m) If a Corporation, State of Incorporation	n) Tax Identification Number

If you would like a contingent owner, please indicate and include this information under question 15, Special Instructions.

UNIVERSAL LIFE INSURANCE COVERAGE DETAILS

8. a) Plan Name: | b) Specified Amount $ _____

c) Death Benefit Option

- ❑ Option 1 (Level)
- ❑ Option 2 (Specified Amount plus Account Value)
- ❑ Option 3 (Specified Amount plus Paid Premium less Withdrawals)

d) Riders

- ❑ Primary Insured Rider — Specified Amount $_____
- ❑ Additional Insured Rider *(complete Form B-1501)* — Specified Amount $_____
- ❑ Accidental Death Benefit Rider — Specified Amount $_____
- ❑ Waiver of Monthly Deductions Rider
- ❑ Terminal Illness Rider
- ❑ Other Rider _____ — Specified Amount $_____

Do not collect premiums if the Specified Amount plus Riders exceeds $500,000.

e) Premiums *(Do not collect premiums if Specified Amount plus Riders exceeds $500,000.)*

Amount Paid with Application $_____ Additional Lump Sum $_____ Planned Premium Payment $_____

f) Mode of Premium Payment:

❑ Annual ❑ Semi-Annual ❑ Monthly Bank Draft Draft Date:_____ *(1st to 28th only)* ❑ Other: _____

WHOLE LIFE INSURANCE COVERAGE DETAILS

9. a) Plan Name: | b) Specified Amount $ _____ or Amount purchased by premium of $ _____

c) Riders

- ❑ Waiver of Premium Rider
- ❑ Accidental Death Benefit Rider — Specified Amount $_____
- ❑ Paid-Up Insurance Rider:
  - ❑ Single Premium Paid-Up Insurance or ❑ Level Premium Paid-Up Insurance: No. of Years _____
  - ❑ Rider Amount of Insurance $_____ or ❑ Amount purchased by premium of $_____
- ❑ Dependent Children Rider — Specified Amount $_____
- ❑ Spouse Rider *(complete Form B-1501)* — Specified Amount $_____
- ❑ Renewable & Convertible Term Rider — Specified Amount $_____
- ❑ Terminal Illness Rider
- ❑ Other Rider_____ — Specified Amount $_____

Do not collect premiums if the Specified Amount plus Riders exceeds $500,000.

d) Premium Amount paid with Application $ _____ *(Do not collect premiums if Specified Amount plus Riders exceeds $500,000.)*

e) ❑ Automatic Premium Loan

f) Mode of Premium Payment:

❑ Annual ❑ Semi-Annual ❑ Monthly Bank Draft Draft Date:_____ *(1st to 28th only)* ❑ Other: _____

TERM LIFE INSURANCE COVERAGE DETAILS

10. a) Plan Name: | b) Specified Amount $ _____ or Amount purchased by premium of $ _____

c) Riders

- ❑ Waiver of Premium Rider
- ❑ Accidental Death Benefit Rider — Specified Amount $_____
- ❑ Dependent Children Rider — Specified Amount $_____
- ❑ Terminal Illness Rider
- ❑ Other Rider_____ — Specified Amount $_____

Do not collect premiums if the Specified Amount plus Riders exceeds $500,000.

d) Premium Amount paid with Application $ _____ *(Do not collect premiums if Specified Amount plus Riders exceeds $500,000.)*

e) Mode of Premium Payment:

❑ Annual ❑ Semi-Annual ❑ Monthly Bank Draft Draft Date:_____ *(1st to 28th only)* ❑ Other: _____

EVIDENCE OF INSURABILITY

11. Question must be completed for all (medical/non-medical) insurance.	Yes	No
Have you:		
a) Ever been declined, postponed, rated or modified for life, health or disability insurance?	❑	❑
b) Submitted any application for life, health, or disability insurance or reinstatement of same which is now pending?	❑	❑
c) Ever engaged in any type of flying as pilot or crew member on any aircraft including ultralight planes, or expect to in the future? If "Yes," complete Aviation questionnaire Form B-1200.	❑	❑
d) Participated in any auto or motorcycle racing, scuba diving, parachuting, hang gliding, paragliding, ballooning or expect to in the future? If "Yes," complete Hazardous Sports questionnaire Form B-1201.	❑	❑
e) Within the past five years been convicted of or pleaded guilty to: (1) Two or more moving violations and/or accidents? If "Yes," include Driver's License No. _____	❑	❑
(2) Driving under the influence of alcohol and/or drugs?	❑	❑
f) Ever been arrested other than for moving violations?	❑	❑
g) If not a US citizen or legal resident of the US and residing permanently outside of the US, do you have any intention of traveling or living in another country in the next two years? If "Yes," indicate where and how long.	❑	❑
h) Are any of the Proposed Insureds residing in a country other than the US: (1) Presently in or held any politcal positions?	❑	❑
(2) Currently in or has served in the Armed Forces?	❑	❑
(3) Currently in or held any governmental positions?	❑	❑
i) (1) In relation to purchasing this policy, have you been offered cash or other valuable consideration as an incentive for you to purchase the policy?	❑	❑
(2) Have there been any representations made to you in connection with the purchase or financing of this policy to the effect that the insurance is free or without cost to you for any period of time?	❑	❑
(3) Does your purchasing this policy include a financing arrangement where a lender or other third party will receive a portion of the death benefit above and beyond the repayment of principle and interest? *If "Yes," provide details below.*	❑	❑

Details of "Yes" answers. Identify question letter and circle applicable items.

12. Insurance currently in force on each person proposed for insurance(Life, Health, Disability, Long Term Care policies or riders to other policies)

If applicant has indicated existing insurance or annuity contracts on below question, our notice #3535 (NAIC 2000) must be executed.

Insurance Company	Policy Number	Year of Issue	Amount of Insurance	Accidental Death Amount	Premium Waiver
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

PERSONAL DATA

13 a). PROPOSED INSURED

Height (Ft/Cm)	Weight (Lbs/Kg)

FAMILY HISTORY

b) Relationship	Age if living	Age at death	Cause of death	c) Relationship	Age if living	Age at death	Cause of death
Father				Brothers			
Mother				Sisters			

Answer question 14 if cash intended to be paid with this application.
If "Yes" to either (a) or (b), cash cannot be accepted and conditional receipt must not be given.

14. Within the past 12 months have you:	Yes	No
a) Been medically diagnosed with or treated for heart trouble, stroke, or cancer, consulted a physician for blood pressure requiring medication, or had an electrocardiogram made for any reason other than a routine physical examination?	❑	❑
b) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	❑	❑

15. Special Instructions

HEALTH STATEMENT

16. a) Personal Physician Last Name	b) Personal Physician First Name	c) E-mail Address		
d) Physician's Address	e) City	f) State/Province	g) Zip Code	h) Telephone Number

17. To the best of your knowledge and belief within the last 10 years, have you been medically diagnosed with or treated for:

MEDICAL CONDITION	Yes	No
a) Disorders of the eyes, glaucoma, cornea? Do not include usual vision correction lenses or routine eye check ups.	❑	❑
b) Disorders of the ears, nose or throat, or hoarseness?	❑	❑
c) Seizures, convulsions, stroke, cerebral infarct, TIA, severe migraines, recurrent or unexplained headaches, epilepsy, dizziness, dizzy spells, aneurysm, paralysis, quadriplegia, mental/nervous disorders or any other disorders of the brain?	❑	❑
d) Pneumonia, bronchitis, asthma, emphysema, allergies, persistent cough, tuberculosis, blood spitting, hemoptisis, chronic respiratory disorder, or any other respiratory or lung disorders?	❑	❑
e) Urinary or genital disorders, kidney stones, renal failure, renal or kidney infections, urinary tract infections, cysts, prostatitis, or sexually transmitted diseases?	❑	❑
f) Hepatitis, cirrhosis, gallbladder stones, cholecystectomy, cholecystitis or any other disorders of the liver or gallbladder?	❑	❑
g) Tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	❑	❑
h) Hyperthyroidism, hypothyroidism, thyroiditis, diabetes mellitus type I or II, goiter, hypoglycemia, blood sugar, disorders of the pancreas, parathyroid glands or endocrine disorders?	❑	❑
i) Duodenal ulcer, gastric ulcer, dyspepsia, indigestion gastritis, intestinal bleeding, diverticulitis or diverticulosis, hemorrhoids, colitis, constipation, esophagitis, hiatal hernia, or any other disorders of the digestive system?	❑	❑
j) High blood pressure, myocardial infarction, heart attacks, murmurs, valve lesions, varicose veins, palpitations, tachycardia, chest pain, coronary heart disease, aneurysm, anemia, rheumatic fever, Chagas disease or any other cardiovascular disorder?	❑	❑
k) Arthritis, neuritis, gout, sciatica, rheumatism, or disorders of the muscles, bones, spine, back or joints, herniated discs, rheumatoid arthritis, osteoporosis or immune (connective tissue) diseases?	❑	❑

MEDICAL CONDITION	Yes	No
l) Skin cancer, surgical scars, non surgical scars, other lesions or disorders of the skin?	❑	❑
m) Anemia, leukemia, hemophilia, phlebitis, thrombophlebitis or any disorders of the blood, vascular system or spleen? Received a blood transfusion?	❑	❑
n) Benign or malignant tumors, cancer, cysts, or lymph gland disorders?	❑	❑
o) Do you smoke cigarettes, pipe or cigars, or use tobacco in any form? Indicate quantity and frequency.	❑	❑
p) Have you quit smoking? Indicate when: 1❑ yr 2❑ yrs 3❑ yrs 10❑ or more	❑	❑
q) Have you had an EKG, X-Ray, or other diagnostic test?	❑	❑
r) Have you within the past five years: 1) Had a check-up, illness, injury or surgery? 2) Been advised to have any diagnostic test or surgery which was not completed? 3) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	❑ ❑ ❑	❑ ❑ ❑
s) Has any immediate family member ever been medically diagnosed with or treated for diabetes, cancer, heart disease, or mental illness?	❑	❑
t) Have you been treated for alcohol or drug abuse?	❑	❑
u) Are you currently under observation or treatment by a physician or a medical facility?	❑	❑
v) For men over 50 years old:	N/A ❑	
1) Have you had a prostate check up?	❑	❑
2) Have you had a PSA test? Indicate dates and results below.	❑	❑
w) For Women:	N/A ❑	
1) Disorders of the ovaries, uterus, breast, lumps, abnormal discharge, or any other gynecological or breast disorder?	❑	❑
2) Have you had a mammogram, PAP smear or gynecological check up recently? Indicate dates, name(s) of physician(s) and results.	❑	❑
3) Are you pregnant? Indicate how many weeks (or months): _____	❑	❑

18. Details of "Yes" answers. Identify question letter and circle applicable items. Include diagnosis, dates, durations, treatments, names, addresses, emails and phone number of doctors or medical facilities.

Question Letter	Diagnosis and treatment of medical conditions or check ups	Name and address/phone/emails of Doctors or Hospitals	Dates

DECLARATION

To the best of his or her knowledge, information and belief, the Proposed Insured (Parent or Guardian if Proposed Insured is under age 18) and Owner (if other than Proposed Insured, Parent or Guardian) represent that the answers and statements made in Parts I (including any supplementary applications) and II (if Part II is required by the Company) of this application are complete and true. The undersigned agrees that:

1. No waiver or modification of a contract provision or of any of the Company's rights or requirements shall be binding upon the Company unless made in writing and approved by the Company;
2. The acceptance of any issued contract will ratify any changes made by the Company in the space "For Home Office Endorsements." However, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent;
3. If, within 60 days from the date of application, no policy is received or I am not notified of approval or rejection, this application shall be deemed declined;
4. $ _____ for life insurance has been paid in cash and the Company's liability will be as stated in the Conditional Receipt. (No other receipt will be valid);
5. If no payment is made with this application, there will be no life insurance or liability
   a) until a policy is delivered;
   b) until the first full premium is paid during the Insured's lifetime; and
   c) as long as no change has occurred in the health of any person proposed for insurance that would place that person in a higher risk class than at the time of application for this policy; and
6. Any contract resulting from this application shall be construed in accordance with the laws of the state named below where this application is signed.

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

PROXY

Important: Not to be Completed in States Where Use of Proxy is Prohibited

(This section is applicable to Pan-American Life Insurance Policies Only)

Under the Articles of Incorporation of Pan-American Life Mutual Holding Company, a policyholder of Pan-American Life Insurance Company ("Pan-American Life") is a member of Pan-American Life Mutual Holding Company. If a policy is issued on the above application, I appoint the persons serving in the capacity of Chairman of the Board of Directors of Pan-American Life, the President of Pan-American Life, and the Corporate Secretary of Pan-American Life, as of the date of a Member Meeting, as my agents to cast my vote as a member of Pan-American Life Mutual Holding Company at any meeting held for the election of directors or for any other purposes (but only to the extent that such appointed persons are policyholders of Pan-American Life). This proxy is subject to revocation at any time.

19. For Home Office Endorsements (For Home Office use only)

Signed at (City)	State	Date signed

Signature of **Primary Proposed Insured** *(Parent or Guardian, if Proposed Insured under age 18)*	Signature of **Owner** *(If other than Proposed Insured) (If Corporation or Partnership, Officer or Partner other than Proposed Insured must sign.)*
X _____	**X** _____

I hereby certify that I truly and accurately recorded on this application the information supplied by the applicant and that I have personally seen every person proposed for insurance under this application. I further certify that I have personally verified the applicant's original government issued identification and that the enclosed are copies of the originals which I have seen. To the best of my knowledge, replacement insurance ❑ is ❑ is not involved in this transaction.

Signature of Soliciting Agent	Personal Code	Participating %	Signature of Soliciting Agent	Personal Code	Participating %
X _____			**X** _____		
Soliciting Agent's Printed Name			Soliciting Agent's Printed Name		
Signature of Soliciting Agent	Personal Code	Participating %	Signature of Soliciting Agent	Personal Code	Participating %
X _____			**X** _____		
Soliciting Agent's Printed Name			Soliciting Agent's Printed Name		

HIPAA AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, authorize any health plan, licensed physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical related facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years to disclose my entire medical record, prescription history, medications prescribed and any other health information that may be considered Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to Pan-American Life Insurance Company or Pan-American Assurance Company. Protected Health Information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I understand that if the protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.

This Authorization expires upon 24 months after the date of signature below, and a copy of this Authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing at any time. Revocation request must be sent in writing to Pan-American Life Insurance Company, HIPAA Compliance Officer, 601 Poydras Street, New Orleans, LA 70130. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protective health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization. I further understand that my application for insurance may not be processed until all the necessary information needed to complete the claims and/or the underwriting process has been received by Pan-American Life Insurance Company or Pan- American Assurance Company.

This protected health information is to be used or disclosed only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective

I certify that I have received a copy of this Authorization.

MEDICAL INFORMATION BUREAU AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency or other organization, institution or person that has any records or knowledge of me or my minor child or my health or my minor child's health to give to Pan-American Life Insurance Company or Pan-American Assurance Company or their reinsurers any such information in order to evaluate my application for life or disability insurance. A photographic copy of this authorization shall be as valid as the original.

I further authorize Pan-American Life Insurance Company or Pan-American Assurance Company or their reinsurers to make a brief report of my protected health information to MIB. I agree that this authorization shall be valid for thirty (30) months from the date signed. I understand that I may request a copy of this authorization. I acknowledge receipt of the Notice Concerning the Medical Information Bureau, the Fair Credit Reporting Act Disclosure and the Abbreviated Notice of Insurance Information Practices.

I understand that I may be interviewed if an investigative consumer report is prepared in connection with this application.

Signature	Name	Date
X _____		

PERSONAL HISTORY INTERVIEW INFORMATION

Please furnish the following information as a personal history interview may be completed in lieu of a commercial inspection report.

Convenient time when Proposed Insured may be reached by phone at:	Home	Business
Has Proposed Insured been informed of a possible telephone call? ❑ Yes ❑ No	E-mail Address	

AGENT'S REPORT

1. How well do you know Proposed Insured?

❑ Well Years _____ ❑ Casually Years _____

❑ Met on solicitation

❑ Relative Relationship _____

2. Proposed Insured's estimated annual income:

Current year $ _____

Prior year $ _____

3. Purpose of Insurance

❑ Family Protection	❑ Pension Max	❑ Section 419	❑ Retirement Income
❑ Income Continuation/Deferred Comp.	❑ Split Dollar	❑ Loan Collateral	❑ Buy Sell Agreement
❑ Key Employee	❑ Gift	❑ Estate Planning	❑ Other _____
❑ Executive Bonus	❑ Mortgage Acceleration	❑ IRA Alternative	_____

4. Have you seen each Proposed Insured at the time of completing this application and reviewed forms of identification?? ❑ Yes ❑ No
If the answer is "No," explain.

5. Other names by which the Proposed Insured(s) is (are) also known (include other last names and maiden names)

6. If any Proposed Insured is under the age of 18, indicate:

a) With whom do they live? _____

b) How many siblings do they have? _____

c) Is every one of them insured? ❑ Yes ❑ No

For equal sums? ❑ Yes ❑ No

Company _____ Face amount $ _____

d) Is the father insured? ❑ Yes ❑ No

Company _____ Face amount $ _____

e) Is the mother insured? ❑ Yes ❑ No

Company _____ Face amount $ _____

7. Requirements for this application:

	Attached	Ordered
Medical Exam / Paramed	❑	❑
Urinalysis	❑	❑
Blood Chemical Profile	❑	❑
Resting Electrocardiogram	❑	❑
Treadmill (Stress EKG)	❑	❑
Financial Statement	❑	❑
Inspection Report	❑	❑
APS Dr. _____	❑	❑
or		
Hospital _____	❑	❑

8. Comments

PAN AMERICAN

P.O. Box 60219, New Orleans, Louisiana 70160

Pan-American Life Insurance Company
Pan-American Assurance Company

CONDITIONAL RECEIPT

THIS RECEIPT MUST NOT BE DETACHED UNLESS CASH IS PAID WITH THIS APPLICATION, AMOUNTS OF INSURANCE ARE WITHIN THE LIMITS IN QUESTIONS 8(e), 9(d) and 10(d); AND QUESTIONS 14(a) and 14(b) ARE ANSWERED "NO." ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Unless each and every term and condition stated on this receipt is fulfilled exactly, no insurance will become effective prior to policy delivery. No agent of the Company, medical examiner, or broker is authorized to alter or waive any of such conditions.

Received from _____ **this** _____ **day of** _____ **20** _____

the sum of $_____ in connection with this application for **Life Insurance**.

I. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery:

Each and every one of the following conditions must be fulfilled **exactly**:

1. The payment received is an amount sufficient to keep the policy or policies applied for in force for a minimum of one month, including any extra premium required for a risk other than standard, and is for the same amount as stated in the application bearing the same date as this receipt; and
2. All required parts of the application, medical examinations, and tests required by Company rules must be completed within 60 days from the date of the application Part I; and
3. On the Effective Date, as defined below, all persons proposed for insurance were insurable risks exactly as applied for according to the practices of the Company governing the acceptance of risks without modification of plan, premium rate or amount; and
4. Questions 14(a) and 14(b) of the application are answered "No."

II. Conditional Insurance Provided

If all of the above conditions are met, then insurance will be provided under the terms and conditions of the policy applied for, subject to the limits in this section which apply during the conditional period, in the same manner and subject to the same rights, conditions, and defenses as if the policy applied for had been issued and delivered.

The total amount of conditional insurance (life insurance, accidental death benefits and disability indemnity) payable in connection with applications for all persons proposed for insurance, will not exceed $500,000 regardless of Face Amount or the applied for amounts. This conditional insurance will take effect on the Effective Date as described.

III. Effective Date of Conditional Insurance

The Effective Date is defined to be the latest of:

1. The date of completion of the application as required;
2. The date of completion of all medical examinations and tests as required;
3. The Policy Date, if any, requested in the application.

IV. Provisions of Conditional Receipt

1. If the Company declines to accept the application and issue the policy for the plan and amount and at the rate of premium applied for without modification, there will be no liability on the part of the Company. The Company will then return the amount paid with this application.
2. The Company has 60 days from the date of the application to consider and act on it. If the applicant does not receive notice of approval or rejection of this application within that period, then this application will be deemed to be declined by the Company.
3. This Conditional Receipt will be void if:
   a. The following information on this receipt does not exactly match the application:
      1. the name of all persons proposed for insurance;
      2. the date;
      3. the description of the payment mode; or
   b. Altered or modified; or
   c. Any check or draft given in payment is not honored.
4. The conditional insurance will terminate on the date a policy is delivered to the Owner, whether or not the policy is issued as applied for.

Signed at _____ **this** _____ **day of** _____ **20** _____

Signature of Soliciting Agent

X _____

AUTHORIZATION TO MAKE WITHDRAWALS FROM MY ACCOUNT

Policy Number(s)			
Name of Account Holder as on Bank or Financial Institution Records		Account Number	
Full Name of Bank or Financial Institution	Transit Number & Routing Number	Draft Date *(1st to 28th only)*	❑ Checking ❑ Savings
Address of Bank or Financial Institution	City	State	Zip Code

I hereby authorize you to make monthly drafts from my account maintained at the above named Bank or Financial Institution. This authorization is limited to payments to the Company in connection with the policy contracts listed above, of:

Monthly Premium Payment of $ _____ Monthly Premium Loan Payment of $ _____

My Bank or Financial Institution has been authorized to pay and charge to my account any withdrawals by and payable to you for this purpose. It will not be necessary for any person employed by the Company to personally authorize such withdrawals. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in making any such withdrawals.

I understand that if any such draft is not honored by my Bank or Financial Institution and any monthly amount due to the Company is not paid within the time stipulated in the policy contract, said policy or contract shall become null and void except as otherwise provided therein. I also understand and agree that if any such draft is not honored, except as a result of an error by the Bank or Financial Institution or the Company, this arrangement may be terminated at the discretion of the Company.

Signature of Account Holder as on Bank or Financial records	Date
X _____	

Attach Voided Blank Check or Deposit Slip Here

IMPORTANT REMINDER

1. List all policy numbers involved.

2. Send entire form to the Home Office with a Voided Blank Check or Deposit Slip.

3. Please type or print full name and address of Bank or Financial Institution.

4. Draft date will be the Effective Date of the policy unless otherwise specified.

5. Draft date must be the first through the twenty-eighth of the month.

THIS NOTICE MUST BE DELIVERED TO THE PROPOSED INSURED WHEN APPLICATION PART I IS COMPLETED

NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Pan-American Life Insurance Company, Pan-American Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life insurance or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734], telephone (866) 692-6901 (TTY 866-346-3642).

Pan-American Life Insurance Company, Pan-American Assurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

FAIR CREDIT REPORTING ACT DISCLOSURE

In making this application, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation and a written summary of your rights under the Fair Credit Reporting Act.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy we need to obtain information about you. Some of that information will come from you and some will come from other sources. The information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have a right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please write to the Underwriting Department, Pan-American Life Insurance Company, P.O. Box 60219, New Orleans, Louisiana. 70160.

❑Pan-American Life Insurance Company
❑Pan-American Assurance Company

P.O. Box 60219, New Orleans, LA 70160 USA

Part I of Application (Please print)

SUPPLEMENTARY APPLICATION

to be added to the following Primary Proposed Insured

1. a) Last Name	b) First Name	c) M. I.	d) Date of Birth

Complete a Supplementary Application for each Proposed Insured you want to add

ADDITIONAL PROPOSED INSURED

2. Coverage: ❑ Spouse Rider ❑ Additional Insured Rider | **3**. Relationship to the Proposed Insured:

4. a) Last Name	b) First Name	c) M. I.	d) Date of Birth	e) Age	f) Gender ❑ M ❑ F

g) Social Security Number / Cedula	h) State of Birth	i) Country of Birth *(If other than US)*	j) Citizenship	k) US Resident? ❑ Yes ❑ No

l) Residential Address	m) City	n) State/Province	o) Zip Code	p) Telephone Number

q) E-Mail Address	r) Driver's License Number	s) D.L. State	t) Current Annual Income	u) Net Worth
			$_____	$_____

v) Risk Classification *(Choose only one from the choices below.)*

❑ Preferred Plus Non-Tobacco ❑ Preferred Non-Tobacco ❑ Standard Non-Tobacco ❑ Preferred Tobacco ❑ Standard Tobacco

5. a) Name of Business *(If independent professional, indicate profession.)*	b) Nature of Business

c) Business Address	d) City	e) State/Province	f) Zip Code	g) Business Phone

h) Describe exact duties/functions of Proposed Insured's work.	i) How long in present job?

j) Presently working? ❑ Yes ❑ No *If "No," please explain under question 15, Special Instructions.*	k) Other employment in last 3 years	l) Percentage of time traveling and places traveled

ADDITIONAL PROPOSED INSURED BENEFICIARIES

6. a) Full Name of Primary Beneficiary	D.O.B.	Relationship	%	b) Full Name of Contingent Beneficiary	D.O.B.	Relationship	%

If you would like the beneficiary designation to be irrevocable, please indicate this under question 11, Special Instructions.

EVIDENCE OF INSURABILITY

7. Question must be completed for all (medical/non-medical) insurance.	Yes	No
Have you:		
a) Ever been declined, postponed, rated or modified for life, health or disability insurance?	❑	❑
b) Submitted any application for life, health, or disability insurance or reinstatement of same which is now pending?	❑	❑
c) Ever engaged in any type of flying as pilot or crew member on any aircraft including ultralight planes, or expect to in the future? If "Yes," complete Aviation questionnaire Form B-1200.	❑	❑
d) Participated in any auto or motorcycle racing, scuba diving, parachuting, hang gliding, paragliding, ballooning or expect to in the future? If "Yes," complete Hazardous Sports questionnaire Form B-1201.	❑	❑
e) Within the past five years been convicted of or pleaded guilty to: (1) Two or more moving violations and/or accidents? If "Yes," include Driver's License No. _____	❑	❑
(2) Driving under the influence of alcohol and/or drugs?	❑	❑
f) Ever been arrested other than for moving violations?	❑	❑
g) If not a US citizen or legal resident of the US and residing permanently outside of the US, do you have any intention of traveling or living in another country in the next two years? If "Yes," indicate where and how long.	❑	❑
h) Are any of the Proposed Insureds residing in a country other than the US: (1) Presently in or held any politcal positions?	❑	❑
(2) Currently in or has served in the Armed Forces?	❑	❑
(3) Currently in or held any governmental positions?	❑	❑
i) (1) In relation to purchasing this policy, have you been offered cash or other valuable consideration as an incentive for you to purchase the policy?	❑	❑
(2) Have there been any representations made to you in connection with the purchase or financing of this policy to the effect that the insurance is free or without cost to you for any period of time?	❑	❑
(3) Does your purchasing this policy include a financing arrangement where a lender or other third party will receive a portion of the death benefit above and beyond the repayment of principle and interest? *If "Yes," provide details below.*	❑	❑

Details of "Yes" answers. Identify question letter and circle applicable items.

8. Insurance currently in force on each person proposed for insurance(Life, Health, Disability, Long Term Care policies or riders to other policies)

If applicant has indicated existing insurance or annuity contracts on below question, our notice #3535 (NAIC 2000) must be executed.

Insurance Company	Policy Number	Year of Issue	Amount of Insurance	Accidental Death Amount	Premium Waiver
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

PERSONAL DATA

9 a). PROPOSED INSURED

Height (Ft/Cm)	Weight (Lbs/Kg)

FAMILY HISTORY

b) Relationship	Age if living	Age at death	Cause of death	c) Relationship	Age if living	Age at death	Cause of death
Father				Brothers			
Mother				Sisters			

Answer question 10 if cash intended to be paid with this application.
If "Yes" to either (a) or (b), cash cannot be accepted and conditional receipt must not be given.

10. Within the past 12 months have you:	Yes	No
a) Been medically diagnosed with or treated for heart trouble, stroke, or cancer, consulted a physician for blood pressure requiring medication, or had an electrocardiogram made for any reason other than a routine physical examination?	❑	❑
b) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	❑	❑

11. Special Instructions

HEALTH STATEMENT

12. a) Personal Physician Last Name	b) Personal Physician First Name	c) E-mail Address		
d) Physician's Address	e) City	f) State/Province	g) Zip Code	h) Telephone Number

13. To the best of your knowledge and belief within the last 10 years, have you been medically diagnosed with or treated for:

MEDICAL CONDITION	Yes	No
a) Disorders of the eyes, glaucoma, cornea? Do not include usual vision correction lenses or routine eye check ups.	❑	❑
b) Disorders of the ears, nose or throat, or hoarseness?	❑	❑
c) Seizures, convulsions, stroke, cerebral infarct, TIA, severe migraines, recurrent or unexplained headaches, epilepsy, dizziness, dizzy spells, aneurysm, paralysis, quadriplegia, mental/nervous disorders or any other disorders of the brain?	❑	❑
d) Pneumonia, bronchitis, asthma, emphysema, allergies, persistent cough, tuberculosis, blood spitting, hemoptisis, chronic respiratory disorder, or any other respiratory or lung disorders?	❑	❑
e) Urinary or genital disorders, kidney stones, renal failure, renal or kidney infections, urinary tract infections, cysts, prostatitis, or sexually transmitted diseases?	❑	❑
f) Hepatitis, cirrhosis, gallbladder stones, cholecystectomy, cholecystitis or any other disorders of the liver or gallbladder?	❑	❑
g) Tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	❑	❑
h) Hyperthyroidism, hypothyroidism, thyroiditis, diabetes mellitus type I or II, goiter, hypoglycemia, blood sugar, disorders of the pancreas, parathyroid glands or endocrine disorders?	❑	❑
i) Duodenal ulcer, gastric ulcer, dyspepsia, indigestion gastritis, intestinal bleeding, diverticulitis or diverticulosis, hemorrhoids, colitis, constipation, esophagitis, hiatal hernia, or any other disorders of the digestive system?	❑	❑
j) High blood pressure, myocardial infarction, heart attacks, murmurs, valve lesions, varicose veins, palpitations, tachycardia, chest pain, coronary heart disease, aneurysm, anemia, rheumatic fever, Chagas disease or any other cardiovascular disorder?	❑	❑
k) Arthritis, neuritis, gout, sciatica, rheumatism, or disorders of the muscles, bones, spine, back or joints, herniated discs, rheumatoid arthritis, osteoporosis or immune (connective tissue) diseases?	❑	❑

MEDICAL CONDITION	Yes	No
l) Skin cancer, surgical scars, non surgical scars, other lesions or disorders of the skin?	❑	❑
m) Anemia, leukemia, hemophilia, phlebitis, thrombophlebitis or any disorders of the blood, vascular system or spleen? Received a blood transfusion?	❑	❑
n) Benign or malignant tumors, cancer, cysts, or lymph gland disorders?	❑	❑
o) Do you smoke cigarettes, pipe or cigars, or use tobacco in any form? Indicate quantity and frequency.	❑	❑
p) Have you quit smoking? Indicate when: 1❑ yr 2❑ yrs 3❑ yrs 10❑ or more	❑	❑
q) Have you had an EKG, X-Ray, or other diagnostic test?	❑	❑
r) Have you within the past five years: 1) Had a check-up, illness, injury or surgery? 2) Been advised to have any diagnostic test or surgery which was not completed? 3) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	❑ ❑ ❑	❑ ❑ ❑
s) Has any immediate family member ever been medically diagnosed with or treated for diabetes, cancer, heart disease, or mental illness?	❑	❑
t) Have you been treated for alcohol or drug abuse?	❑	❑
u) Are you currently under observation or treatment by a physician or a medical facility?	❑	❑
v) For men over 50 years old:	N/A ❑	
1) Have you had a prostate check up?	❑	❑
2) Have you had a PSA test? Indicate dates and results below.	❑	❑
w) For Women:	N/A ❑	
1) Disorders of the ovaries, uterus, breast, lumps, abnormal discharge, or any other gynecological or breast disorder?	❑	❑
2) Have you had a mammogram, PAP smear or gynecological check up recently? Indicate dates, name(s) of physician(s) and results.	❑	❑
3) Are you pregnant? Indicate how many weeks (or months): _____	❑	❑

14. Details of "Yes" answers. Identify question letter and circle applicable items. Include diagnosis, dates, durations, treatments, names, addresses, emails and phone number of doctors or medical facilities.

Question Letter	Diagnosis and treatment of medical conditions or check ups	Name and address/phone/emails of Doctors or Hospitals	Dates

DECLARATION

To the best of his or her knowledge, information and belief, the Proposed Insured (Parent or Guardian if Proposed Insured is under age 18) and Owner (if other than Proposed Insured, Parent or Guardian) represent that the answers and statements made in Parts I (including any supplementary applications) and II (if Part II is required by the Company) of this application are complete and true. The undersigned agrees that:

1. No waiver or modification of a contract provision or of any of the Company's rights or requirements shall be binding upon the Company unless made in writing and approved by the Company;
2. The acceptance of any issued contract will ratify any changes made by the Company in the space "For Home Office Endorsements." However, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent;
3. If, within 60 days from the date of application, no policy is received or I am not notified of approval or rejection, this application shall be deemed declined;
4. $ _____ for life insurance has been paid in cash and the Company's liability will be as stated in the Conditional Receipt. (No other receipt will be valid);
5. If no payment is made with this application, there will be no life insurance or liability
   a) until a policy is delivered;
   b) until the first full premium is paid during the Insured's lifetime; and
   c) as long as no change has occurred in the health of any person proposed for insurance that would place that person in a higher risk class than at the time of application for this policy; and
6. Any contract resulting from this application shall be construed in accordance with the laws of the state named below where this application is signed.

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

MEDICAL INFORMATION BUREAU AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency or other organization, institution or person that has any records or knowledge of me or my minor child or my health or my minor child's health to give to Pan-American Life Insurance Company or Pan-American Assurance Company or their reinsurers any such information in order to evaluate my application for life or disability insurance. A photographic copy of this authorization shall be as valid as the original.

I further authorize Pan-American Life Insurance Company or Pan-American Assurance Company or their reinsurers to make a brief report of my protected health information to MIB. I agree that this authorization shall be valid for thirty (30) months from the date signed. I understand that I may request a copy of this authorization. I acknowledge receipt of the Notice Concerning the Medical Information Bureau, the Fair Credit Reporting Act Disclosure and the Abbreviated Notice of Insurance Information Practices.

I understand that I may be interviewed if an investigative consumer report is prepared in connection with this application.

15. For Home Office Endorsements (For Home Office use only)

Signed at (City)	State	Date signed

Signature of **Additional Insured** *(Parent or Guardian, if Proposed Insured under age 18)*	Signature of **Owner** *(If other than Proposed Insured) (If Corporation or Partnership, Officer or Partner other than Proposed Insured must sign.)*
X _____	**X** _____

I hereby certify that I truly and accurately recorded on this application the information supplied by the applicant and that I have personally seen every person proposed for insurance under this application. I further certify that I have personally verified the applicant's original government issued identification and that the enclosed are copies of the originals which I have seen. To the best of my knowledge, replacement insurance ❑ is ❑ is not involved in this transaction.

Signature of Soliciting Agent	Personal Code	Participating %	Signature of Soliciting Agent	Personal Code	Participating %
X _____			**X** _____		
Soliciting Agent's Printed Name			Soliciting Agent's Printed Name		
Signature of Soliciting Agent	Personal Code	Participating %	Signature of Soliciting Agent	Personal Code	Participating %
X _____			**X** _____		
Soliciting Agent's Printed Name			Soliciting Agent's Printed Name		

HIPAA AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, authorize any health plan, licensed physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical related facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years to disclose my entire medical record, prescription history, medications prescribed and any other health information that may be considered Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to Pan-American Life Insurance Company or Pan-American Assurance Company. Protected Health Information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I understand that if the protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.

This Authorization expires upon 24 months after the date of signature below, and a copy of this Authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing at any time. Revocation request must be sent in writing to Pan-American Life Insurance Company, HIPAA Compliance Officer, 601 Poydras Street, New Orleans, LA 70130. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protective health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization. I further understand that my application for insurance may not be processed until all the necessary information needed to complete the claims and/or the underwriting process has been received by Pan-American Life Insurance Company or Pan- American Assurance Company.

This protected health information is to be used or disclosed only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective

I certify that I have received a copy of this Authorization.

Signature	Name	Date
X _____		

SERFF Tracking #:	*PNAL-128740625*	***State Tracking #:***		***Company Tracking #:***	*1500AR*

State:	*Arkansas*	***Filing Company:***	*Pan-American Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.003 Single Life - Single Premium*		
Product Name:	*Individual Life Applications Primary and Supplemental*		
Project Name/Number:	*/1500AR*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	AR cover letter		
Comments:			
Attachment(s):			
AR Cover letter.pdf			

San J. Llull
Senior Compliance and Policy Analyst
601 Poydras Street
New Orleans, LA 70130
E-mail: sllull@palig.com
(504-566-3449

October 24, 2012

NAIC # 67539
FEIN # 72-0281240

Jay Bradford
Department of Insurance
State of Arkansas
1200 W. Third Street
Little Rock, AR 72201

RE: 2012 Revisions to our Applications

Attn: Policy Form Filings

The applications we listed below have been updated in the following sections:

1. The HIPAA new conditions
2. The Medical Information Bureau (MIB).
3. Producer Certification with the "Anti Money Laundering" regulations.

The form number on the lower left corner remains the same except the Revision Date has been changed to 01-13. No other alterations have been made to the forms.

B-1500 (AR) Rev 01-13 Previously approved on ……4-6-07
B-1501 (AR) Rev 01-13 " " "……4-6-07

Please review and approve the above applications at your earliest convenience. If you need more information, please contact me at 504-566-3449. Thank you for your time and consideration.

San J. Llull
Senior Compliance and Policy Analyst